This packet is an example of the order in which documents should be filed. These are not examples of how to fill out forms/documents.

STATE OF CALIFORNIA
DWC DISTRICT OFFICE

DOCUMENT COVER SHEET

Is this a new case? Yes ☐ No ☑ Companion Cases Exist ☐ Walkthrough Yes ☐ No ☐

More than 15 Companion Cases ☐

09/10/2008
Date:(MM/DD/YYYY)

SSN: 000-00-0000

☐ Specific Injury

VOC12345
Case Number 1

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

Please check unit to be filed on (check only one box)

☐ ADJ ☐ DEU ☐ SIF ☐ UEF ☑ VOC ☐ INT ☐ RSU

Companion Cases

☐ Specific Injury

Case Number 2

☐ Cumulative Injury (Start Date: MM/DD/YYYY) (End Date: MM/DD/YYYY)

(If Specific Injury, use the start date as the specific date of injury)

Body Part 1: _____ Body Part 3: _____

Body Part 2: _____ Body Part 4: _____

Other Body Parts: _____

DOCUMENT SEPARATOR SHEET

Product Delivery Unit: VOC

Document Type: DWC - REHAB FORMS

Document Title: RU-122 SETTLEMENT OF PROSPECTIVE VOC REHAB SERVICES

Document Date: _____ MM/DD/YYYY

Date of document following Document Separator Sheet

Author: UNIFORM ASSIGNED NAME

If you are the Claims Administrator or the Hearing Representative use your Uniform Assigned Name. For unrepresented Injured Worker and others, "Author" is the document author.

Office Use Only

Received Date: _____ MM/DD/YYYY

SETTLEMENT OF PROSPECTIVE VOCATIONAL REHABILITATION SERVICES [LC § 4646 (b)]

REHABILITATION USE ONLY

Social Security No:	Claim Number:	WCAB Case No. (if any):	RU Case No. (if any):
Employee Name (Last) (First) (MI)			Date of Birth
Address (Street) (City) (State) (Zip Code)			

Date of Injury	If Self Insured, Certificate Name or Insurer Name
Employer Name	Adjusting Agency Name (if adjusted)
Employer Address	Claims Mailing Address
City, State, Zip Code	City, State, Zip Code
Employee's Attorney	Employer's Representative
Firm Name	Firm Name
Address	Address
City, State, Zip Code Phone No.	City, State, Zip Code Phone No.
Qualified Rehabilitation Representative *(if any)*	
Firm Name	
Address	
City, State, Zip Code Phone No.	

In accordance with Labor Code 4646:

1. **The parties to this agreement are the employee _____ and the employer or claims administrator_____.**
2. **All parties agree that any vocational rehabilitation benefits paid and accrued prior to the date this agreement has been signed are separate and distinct funds from the amount settled in this agreement.**

3. The parties hereby agree to settle the employee's right to prospective Vocational Rehabilitation services with a one-time payment to the employee for the sum of $ _____, less the sum of $ _____, as reasonable attorney's fee. The requested attorney's fee will be held in trust by the employer subject to approval and subsequent order by the Workers' Compensation Appeals Board.

4. The employee's attorney has fully disclosed and explained to the employee the nature and quality of the rights and privileges being waived and settled by the parties. The employee has knowingly and voluntarily agreed to relinquish his or her rehabilitation rights.

Employee's signature _____ **Date** _____

Employee's Attorney's signature _____ **Date** _____

Qualified Interpreter's signature _____ **Date** _____
(if needed)

5. The employee understands and agrees that the settlement is to be applied to his/her self-directed vocational rehabilitation, such as direct placement, training, self-employment.

Signatures

Employee_____ Date_____

Employee's Attorney_____ Date_____

Employer's Representative_____ Date_____

Determination of the Rehabilitation Unit

The Rehabilitation Unit has reviewed this Settlement Agreement pursuant to Labor Code § 4646 (b) and (c). The Rehabilitation Unit, hereby, **approves** this Settlement Agreement.

Rehabilitation Unit Consultant_____ **Date**_____

OR

The Rehabilitation Unit has reviewed the Settlement Agreement pursuant to Labor Code § 4646 (b) and it is, hereby, **disapproved.** Reason for Disapproval:_____
_____

Rehabilitation Unit Consultant_____ **Date**_____

The Rehabilitation Unit shall approve or disapprove the settlement agreement of vocational rehabilitation. If disapproval is not made within ten (10) days of receipt of a fully executed agreement, the agreement shall be deemed approved.

This Agreement is Final. Any aggrieved party must file an appeal with the Workers' Compensation Appeals Board within twenty (20) days from the date this Agreement is approved, deemed approved or disapproved.

If Vocational Rehabilitation Services were commenced:

Summary of Services Provided

Number of weeks of VRMA: _____

Total Amount VRMA Paid: $_____

Total Amount of PD Supplement: $_____

Amount Paid QRR for:

DOI's on or after 1/1/03

Phase A: $_____

Phase B: $_____

Total costs of QRR services $_____

QRR Name _____

Total other costs of rehabilitation services: $ _____

Amount withheld for Employee's Representative, if any: $ _____

If plan developed, plan type: _____

Completed by: _____ Date: _____